The Commodification and Appropriation of Ethnomedicine:
Examining Ecuador’s Indigenous Medicinal Traditions through the Lens of the Indigenous Revitalization Movement

A SENIOR CAPSTONE PROJECT
Presented to
The Department of Anthropology
The Colorado College

In Partial Fulfillment of the Requirements for the Degree
Bachelor of Arts

By:
Caitlin Hegg
May 2018

Approved: Christina Leza
Date: April 17, 2018
TABLE OF CONTENTS

INTRODUCTION .................................................................................................................. 3
CROSS CULTURAL LITERATURE REVIEW ................................................................. 6
HISTORICAL OVERVIEW OF INDIGENOUS REVITALIZATION ............................ 13
METHODS.......................................................................................................................... 16
  Study Sites .................................................................................................................. 16
  Data Collection ......................................................................................................... 23
RESULTS ........................................................................................................................... 29
  Pharmacies and Ethnomedicinal Sales ................................................................. 29
  Statistical Data from the Ecuadorian Government ........................................... 30
  Interviews with a Traditional Curandero ........................................................... 36
  Jambi Huasi Causi, Intercultural Clinic ............................................................... 41
  Observations of a Host Family ........................................................................... 43
CULTURAL ANALYSIS .................................................................................................. 45
  Revitalization Theory ............................................................................................. 45
  Relationship between Indigenous Revitalization and Ethnomedicine .......... 47
  Cultural Implications and Effects ......................................................................... 51
  Significance of the Relationship ........................................................................... 55
CONCLUSION .................................................................................................................... 57
  Limitations and Implications for Future Research ............................................. 58
REFERENCES .................................................................................................................... 63

ACKNOWLEDGEMENTS: I would like to thank the Colorado College Anthropology Department, especially Christina Leza, Mario Montaño, and Krista Fish for their support and guidance throughout the writing process. Additional thanks to Jambi Huasi Centro de Medicina Alternativa in Otavalo, Ecuador, Tayta Rafael Pineda Diaz, the Mancheno-Bustillos family, and participating pharmacies in Otavalo and Cuenca, Ecuador for their time and help with data collection.

HONOR CODE: On my honor, I have neither given, nor received, any unauthorized aid on this project. Honor Code upheld.
- Caitlin Hegg
Introduction

The western world has traditionally seen biomedicine, or western medicine, as the only valid form of medicine and healing. Vaccines and antibiotics have saved hundreds of thousands of lives, and are often pointed to as the best way to help developing nations avoid diseases such as cholera or malaria and further their development and westernization (World Health Organization 2017). However, many of these nations have their own regional histories of traditional medicinal practice and healing. The adoption of the U.N. Declaration on the Rights of Indigenous Peoples (UNDRIP) by 143 member states in 2007 has helped to strengthen the indigenous movement in Ecuador and to affirm the rights of indigenous peoples to economic development and security and the maintenance of their traditions, languages, and cultural practices (Carrie et. al 2015). The addition of Sumak Kawsay, or the principle of harmonious living, to the 2008 revision of the Ecuadorian constitution has also furthered these rights and the indigenous revitalization movement (Larrea Maldonado 2011). One of the traditions being revived and made more visible and publicly accepted is indigenous medicine, also known as ethnomedicine.

Ethnomedicine is defined as the “folk illnesses, traditional medical systems, herbal remedies and healing rituals” of indigenous cultures (Nichter 1990, ix). The indigenous revitalization movement, which advocates for the advancement of rights and pride in indigenous traditions, has allowed for the ethnomedicine to become more publicly acceptable and therefore more widely accessible in Ecuador, so that natural medicines, teas, and tinctures which make use of indigenous knowledge are available at pharmacies, and clinics offer ethnomedicinal treatments side by side with biomedicines in
areas with high indigenous populations. This commodification of ethnomedicine reflects the success of the indigenous revitalization movement and the ways in which Ecuadorian citizens are attempting to navigate their position in a developing nation experiencing the effects of globalization and colonialism, while maintaining their traditional heritage and practices regardless of whether the citizens identify as indigenous, mestizo, or people with mixed indigenous and European ancestry, or neither indigenous or mestizo.

The word ‘commodification’ (and various versions of the word) will be used throughout this paper to convey meaning similar to the anthropological term ‘cultural appropriation.’ Cultural appropriation is the representation, use, or possession of distinct cultural practices, styles, experiences, or objects by nonmembers (Matthes 2016, 343). However, this paper will use both the terms ‘commodification’ and ‘cultural appropriation,’ which are understood as differing in meaning and application. The westernization occurring with ethnomedicine allows for urban Ecuadorians who identify as indigenous or mestizo to have convenient access to their traditional medicinal practices. Therefore, although many nonmembers are also using ethnomedicine in a way that is consistent with definitions of cultural appropriation, and indeed some have traveled to Ecuador and other South American countries to receive these medicines, the term ‘commodification’ will also be used to distinguish that indigenous and mestizo populations in urban Ecuador also benefit from the westernization of sales of ethnomedicine. Furthermore, as participants in the indigenous revitalization movement, these groups are contributors to this commodification. Finally, ‘commodification’ can also refer to goods entering a capitalist market, and as this theme is relevant to and present throughout this study, there is a dual meaning behind the use of this term.
An understanding of the ways in which communities can retain their identities and uphold traditions while simultaneously adapting to the changes that inherently accompany globalization is important for the communities undergoing these changes (Hall and Fenelon 2009). It is also important for communities who are struggling with the same issues to see how others have adapted to these challenges, and for colonizing cultures to relearn how to interact with historically oppressed communities without imposing their beliefs and ideals. Furthermore, this study will inform the field of anthropology by providing a holistic approach to the commodification and appropriation of ethnomedicine in relation to the indigenous revitalization movement.

While it is always important to acknowledge the ongoing effects of globalization, the indigenous rebirth movement is reinvigorating Ecuadorian life with traditional Andean culture (Colloredo-Mansfeld 2009; Gold and Clapp 2011). The ways in which Ecuadorians are navigating increasing globalization and westernization while simultaneously returning to their indigenous roots are widespread and varied. This paper examines the relationship between westernization and the return to indigenous traditions through the lens of ethnomedicine, and posits that the growth of ethnomedicine is due to the indigenous revitalization movement. The movement has reclaimed this tradition and pride for their natural medicinal practices, which are increasingly visible and accessible to all Ecuadorians through the commodification of ethnomedicines.

A cross-cultural analysis of ethnomedicine will allow for the exploration of multiple definitions of ethnomedicine and of ethnomedicinal practices in various Latin/South American countries. This research then provides historical context for the indigenous revitalization movement in Ecuador prior to presenting the data regarding
ethnomedicine usage and the commodification of ethnomedicine. The research methodology will be explained in the methods section, and the data from research conducted in Ecuador will be presented in the data section. The data includes various forms such as interviews, surveys, and personal observations. Surveys gathered information about the sale of ethnomedicines in pharmacies such as the types sold, and their popularity relative to biomedical treatments. One interview, which occurred over three visitation periods, was with a traditional Quechuan *curandero* and demonstrated the belief of the *curandero* that ethnomedicine should work in tandem with biomedicine as complementary healing methods and not as alternatives, while the other interview at Jambi Huasi clinic in Otavalo showed that the clinic offers both ethnomedicine and biomedicine treatments at the same location in order to better meet the needs of their community. Natural medicines sold at pharmacies and from food-cart-style venues show that the indigenous movement has not only reclaimed indigenous pride of ethnomedicine, but has contributed to the commodification of ethnomedicine using capitalist methods. Statistics relating to public health and policies in Ecuador will also be presented as supplementary data. Finally, the data will be analyzed through revitalization and anthropological theories in order to explore the manner in which this movement is helping lead to the commodification and appropriation of ethnomedicine.

**Cross-Cultural Literature on Ethnomedicine**

As previously mentioned, ethnomedicine refers to the “folk illnesses, traditional medical systems, herbal remedies and healing rituals” of indigenous cultures (Nichter 1990, ix). However, another definition of ethnomedicine refers to “a study of the full range and distribution of health related experience, discourse, knowledge, and practice
among different strata of a population; the meaning… for peoples at a given historical junction” (Nichter 1900, ix). A third definition deals with the “transformations in popular health culture and medical systems concordant with social change; and the social relations of health related ideas, behaviors and practices” (Nichter 1990, ix). In this study, all definitions are applicable. This research uses the first definition of ethnomedicine as the working definition for this paper due to its broader scope, while simultaneously incorporating the second and third definitions through the exploration of the commodification of indigenous medicines. In understanding and examining how ethnomedicine is being westernized and appropriated in Ecuador, this study is inherently comparing how different cultures and people deal with disease, and how this changes due to globalization, thus utilizing the second and third definitions provided in this paper.

Ecuador has been largely overlooked in the study of ethnomedicine, which is interesting given that it has a high percentage of indigenous and mestizo populations, and contains four very distinct geographic locations (Figure 1). These regions are the coast, the Andes (also known as the Sierra or highlands region), the Amazon, and the Galapagos. The geographic differences among these regions have led to distinct cultures and, therefore, different ethnomedicinal practices (Colloredo-Mansfeld 2009). Due to the lack of case studies on Ecuador, the examination of previous literature and research of ethnomedicine in South America will be from a cross-cultural perspective. An abundance of case studies have been published regarding the different ethnomedicinal practices of different communities in Latin and South American countries, especially Bolivia and Nicaragua. These studies will be used to provide context of ethnomedicine and its use
and integration into westernizing societies in South America as a way of providing a broad understanding of the events in Ecuador.

Figure 1 – Geographical Map of Ecuador showing the unique geographic features (Galapagos absent). Blue lines indicate rough geographic boundaries, black line shows country boundary. Image taken from https://upload.wikimedia.org/wikipedia/commons/thumb/d/d5/Ecuador_relief_location_map.svg/2000px-Ecuador_relief_location_map.svg.png

Focusing on the Miskitu people of eastern Nicaragua, Carrie et al. (2015) examined the integration of biomedicine and traditional medicine through the lens of the
UNDRIP Article 24, an article that affirms the rights of indigenous peoples to their traditional medicines and health practices as well as to all social and health services. The Nicaraguan government is also noted for making changes in the constitution to lead to the integration of traditional medicine and biomedicine at both a regional and national level (Carrie et. al 2015). Wedel (2009) also worked with the Miskitu people, focusing on ailments caused by spirits, sorcery, or other illnesses that “fall outside the scope of biomedical comprehension” (Wedel 2009:50). Wedel (2009) concluded that biomedicine officials needed to recognize that they are only one element of healing to the Miskitu people, and that the biomedicine leaders in the community need to be more tolerant of these diverse practices and learn to support, encourage, and participate in attempts at mediating the line between western and indigenous medicine practices. The need for acceptance of diverse healthcare practices identified by Wedel (2009) is related to changes that were made in Bolivia regarding healthcare policies.

Babis (2014) investigated the circumstances that led to the changes in Bolivian healthcare policies resulting in the institutionalization of indigenous medicine. One finding showed that the recent global interest in alternative medicine helped lead to the Bolivian policy changes (Babis 2014). This research is relevant to this study, since it suggests that alternative medicine practices such as traditional and indigenous medicines are gaining in popularity, which could be an economic incentive and a contributing factor to the commodification of ethnomedicine. Furthermore, the continued institutionalization and commodification of indigenous medicine practices will inherently lead to the need for restructuring and creating new policies regarding medicine and healing, while simultaneously changing the way medicine and healing are used and conceptualized in
Bolivia. Since the global interest that led to the institutionalization of traditional medicine in Bolivia is also occurring in Ecuador, there is the possibility for this full institutionalization of ethnomedicine, and these findings are therefore applicable to Ecuador.

Also in Bolivia, Bruun and Elverdam (2006) examined the ways in which *los Naturistas*, a healing group found in urban areas, made an ethnomedicinal-healing niche through the selective integration of biomedicine and ethnomedicine. *Los Naturistas* have created a new hybrid and pluralistic system of medical treatments that combines traditional illness explanatory methods from ethnomedicine with biomedical explanations (Bruun and Elverdam 2006). Furthermore, *los Naturistas* refer patients to biomedical officials if they have doubts about the diagnosis, but *los Naturistas* claim that the patients always choose to return back to *los Naturistas* for ethnomedicinal treatments for their diagnosis (Bruun and Elverdam 2006). The authors do not address why the patients choose to return to *los Naturistas*. The ways in which *los Naturistas* have negotiated a position for themselves within the societal demands for ethnomedicine while navigating the growth of biomedical technologies and innovations offers one unique aspect of the commodification of ethnomedicine in Bolivia, which helps to inform and direct this research based in Ecuador.

In Chile, Torri (2012) examined the Mapuche culture and the intercultural healthcare practices in the Makewe Hospital for an equal recognition of biomedicine and ethnomedicine. Ultimately, the study concluded that without a valorization of indigenous culture, effective and equitable intercultural health practices would be impossible (Torri 2012). As the indigenous revitalization movement continues rejuvenating ethnomedicine
in Ecuador, it is interesting to consider whether Ecuador will soon be attempting more
intercultural health care practices and facilities on a broader scale. Furthermore, it poses
the question of whether the commodification of ethnomedicine is an effective and
equitable way to distribute ethnomedicine, and if it is a valorization of indigenous culture
or a form of cultural appropriation, as defined in the introduction.

Gold and Clapp (2011) demonstrated that the healthcare preferences of members
of a remote Peruvian village for choosing medicinal plants over western biomedicines are
part of a larger discourse on the revitalization of the Andean identity. Ecuador and Peru
share very similar Andean ancestries, and the indigenous revitalization movement
occurring throughout Latin and South America includes and is highly prevalent in both of
these countries. Consequently, the research of Gold and Clapp (2011) both pertains to
and is related to the healthcare choices of Ecuadorians. The Peruvian village’s choice of
medicinal plants over biomedical pharmaceuticals could reflect the choices that remote
Ecuadorian villages might also make, and could inform the choices regarding
ethnomedicine or biomedicine usage by indigenous immigrants and mestizos in urban
cities.

In one of the few studies conducted in Ecuador, Rosales-Rivadeneira, Álvarez-
Moreno, and Tito-Pineda (2017) looked at the indigenous cosmovisions of Otavalan
women on health and illness. They found that the mestizo population largely prefers
ethnomedicine, with statistics showing that 43% of Ecuadorian citizens who are sick
prefer to use traditional healing methods (Rosales-Rivadeneira, Álvarez-Moreno, and
Tito-Pineda 2017, 976). They also found that ancestral medicine is considered a
complement to biomedicine and that the Andean cosmovision about health, which posits
that illness is a result of a rupture between the harmony of the body-soul-nature relationship, is so deeply engrained in the indigenous culture that it continues the trust and reliance on ethnomedicine (Rosales-Rivadeneira, Álvarez-Moreno, and Tito-Pineda 2017). This research is significant to this study, not only because it occurs in Ecuador, but also because it demonstrates how the revitalization of indigenous culture could further reinforce reliance on ethnomedicinal treatments, and demonstrates the popularity of ethnomedicine in Ecuador.

Tinitana et. al (2016) researched the medicinal plants sold at traditional markets in southern Ecuador looking for culturally important plants and common treatment usages. This investigation led to the conclusion that public policies are important for the trade and quality of medicinal plant resources, and, perhaps more importantly, that the maintenance of these traditional markets is upheld by the low price of medicinal plants, confidence in ethnomedicine, and the sociocultural environment (Tinitana et. al 2016). Many traditional healers either send their patients to purchase specific plants with directions on how to prepare them or the healers themselves go to buy the plants they then give to their patients as treatment (Rafael Pineda Diaz, Personal Interview 10/21/2016). These traditional markets are maintained by both confidence in ethnomedicine, and the sociocultural environment, and it is quite interesting to consider how Ecuador’s sociocultural environment is both maintaining ethnomedicine in its original, historical use while simultaneously allowing for the commodification of ethnomedicine.

Previous research regarding ethnomedicine has been scattered throughout Latin/South America, with very few studies centered on Ecuador. Many of these studies
are interested in the integration of biomedicine and ethnomedicine, taking various approaches to analyze the different integration methods and evaluate their relative successes. Other research focuses on the supernatural and magical elements of ethnomedicine, which are unique to ethnomedicine and often contradictory to biomedicine, complicating the integration of these two different health care approaches (Wedel 2009). Research on ethnomedicine as a traditional and culturally appropriate alternative to over-the-counter biomedicine is scarce and hard to come by. This research hopes to fill that gap by examining ethnomedicinal commodification in Ecuador through the lens of the indigenous revitalization movement.

**Historical Context of Ecuador’s Indigenous Revitalization Movement**

In order to understand the relationship between the indigenous revitalization movement and commodification and appropriation of ethnomedicine, and prior to any analysis of this relationship, a contextual overview of the indigenous movement in Ecuador must first be established. The indigenous movement in Ecuador is set apart from similar movements in other Latin American countries because it has a national-level organization which focuses on garnering political power to advance indigenous needs, fight against racism, neglect, and loss of territory by the state (Clark and Becker 2007; Colloredo-Mansfeld 2009).

In the highland Sierra region, where the research of this study took place, indigenous peoples had few political resources in the early 1900s, however they allied with the Ecuadorian communist party in the 1930s to reclaim land that haciendas, large plantation-like farms, had taken from them (Colloredo-Mansfeld 2009). When the Ecuadorian government passed the first serious land-reform law in 1964, indigenous
communities were legally allowed to sue for underutilized land and, as these communities sought official recognition, they were able to acquire more land (Colloredo-Mansfeld 2009). However, small-scale farming is a hard way to make a living, and in the 1970s, new grass-roots organizations “emerged to lead first the struggle for land and then the wider defense of Kichwa peoples against new hardships” in all the geographic areas of Ecuador (Colloredo-Mansfeld 2009, 10).

In 1986, the first national group, the Confederación de Nacionalidades Indígenas del Ecuador (CONAIE) was organized, representing native peoples from the coast, the Amazon, and the Andes (Clark and Becker 2007; Colloredo-Mansfeld 2009). This organization gained national and international attention in 1990 when “an impressive indigenous uprising paralyzed the country for several weeks” (Clark and Becker 2007, 1). Members of the organization marched on provincial capitals and the national capital of Quito, refused to sell their produce in markets, and barricaded the Pan-American Highway, the crucial north-south transportation route through the country. These protests continued until “the government agreed to negotiate a 16 point agenda presented by CONAIE” (Clark and Becker 2007, 1). Although CONAIE came away with few concessions on this agenda, there were also several impressive gains. At the local level, more land began to move into indigenous hands, as nervous hacienda owners began to make private sales, and on a national level, the ethnicity question had been introduced into national politics, moving from “peasant struggles to Indian resistance” (Colloredo-Mansfeld 2009, 81).

Since the 1990s, the Ecuadorian indigenous movement has continued to have “a significant impact” and still advocates for indigenous rights (Lalander 2010, 505).
However, CONAIE, one of the principal organizations of the movement, has experienced tensions, conflicts, and internal divisions, as has Pachakutik and ECUARUNARI, two of the other major organizations fighting for indigenous rights (Lalander 2010). Despite these conflicts, the indigenous movement in Ecuador remains one of the strongest in South America (Lalander 2010). The movement has made significant progress in furthering bilingual education and rural development, and contributed to the relatively peaceful overthrow of two national governments in 1997 and 2000 (Lalander 2010). These parties have not only united indigenous peoples and communities, but have helped indigenous and mestizo peoples to gain political power through elected positions (Lalander 2010). One such example is in Otavalo, where the first indigenous mayor, Mario Conejo, was elected in 2000. Conejo is one of the most successful and recognized mayors in Ecuador to this day for his intercultural banner and for the movement Minga Intercultural, started by his supporters (Lalander 2010). _Minga _is a “concept full of indigenous symbolism reflecting identity, solidarity, and ethnicity,” and directly translates to ‘collective work in communitarian support’ in Kichwa (Lalander 2010, 512).

In 1998, the Ecuadorian constitution formally recognized indigenous peoples, and defined the Ecuadorian state as “pluricultural and multiethnic,” a form of symbolic recognition to guarantee the existence of indigenous forms of social organization, customary law, internal jurisdiction over community affairs, the right of indigenous communities to own property in common, and bilingual education (Clark and Becker 2007). In 2008, when the constitution was once again updated, the indigenous movement negotiated the inclusion of the idea of _Sumak Kawsay _, in Kichwa, or _buen vivir_, in Spanish. The concept of _Sumak Kawsay_ deals with the harmony of all relationships,
especially between humans, ancestors, community, nature, and the past and present (Larrea Maldonado 2011, 60). *Sumak Kawsay* also incorporates the capacity and need to coexist and support each other, humans supporting nature as nature supports us, and recognizes the rights of the natural world (Irigaray et.al 2016; Larrea Maldonado 2011).

Since the election of president Rafael Correa in 2007, tensions within the indigenous movement have heightened and further complicated. Lalander (2010) interprets the ‘Correa effect’ as that Correa has taken advantage of a power vacuum, and “mobilized a kind of cooptation of social organizations that had experienced political crises of representation” (515). Support for Correa’s presidency divided indigenous communities and organizations, as FENOCIN, an indigenous peasant confederation supported him while other groups such as ECUARUNARI opposed Correa, and groups including CONAIE and Pachakutik were internally divided on the issue (Lalander 2010). In May of 2017, Lenín Moreno was elected to the presidency of Ecuador, and his political stances and the effects they will have on the indigenous movement in Ecuador have yet to be explored or understood.

**Methodology**

**Study Sites**

The cities in which the majority of the research was conducted – Quito, Cuenca and Otavalo – were chosen because of their stark differences (Figure 2). Quito (Figures 3 and 4), the capital of Ecuador, is located in the north-central part of the Sierra region of the country. Quito is an urban city experiencing rapid population growth, with many

---

1 The original quote is in Spanish, and reads “…el *Sumak Kawsay*, la vida plena, que implica amplias relaciones, entre los seres humanos, a naturaleza, la vida comunitaria, los ancestros, el pasado y el futuro”
indigenous peoples and mestizos migrating to the city or working weekdays in the city and returning to rural hometowns on the weekends (Bravo-Ureta, Quiroga, and Brea 1996; Rudel 2006). Cuenca (Figures 5 and 6) is a city in the Sierra region of southern Ecuador that is also experiencing a large population growth. Both Quito and Cuenca are listed on the UNESCO world heritage site list for the historic Spanish architecture present throughout the two cities (UNESCO, City of Quito & Historic Center of Santa Ana de los Rios de Cuenca). In recent years, Cuenca has experienced a large growth of ex-patriots moving to the city, and the colonial history of the city combined with the influx of westerners has changed the city’s demographics (Hayes 2014). Otavalo (Figures 7 and 8), on the other hand, has become known as the “indigenous capital” of Ecuador, and has successfully managed to turn Kichwan traditional crafts into a thriving artisanal market for tourists (Lalander 2010, 508). Located in the northern part of the Sierra region of Ecuador, Otavalo is a much smaller city than Quito or Cuenca, and the surrounding rural areas have a high population of self-identifying indígenas and mestizos (INEC 2010). While Quito and Cuenca represent the westernization of Ecuador, Otavalo represents the traditional and indigenous.
Figure 2 – Map of Ecuador, showing Cuenca, Otavalo, and Quito, the cities in which data was collected. Map taken from Univeristy of Texas Library Map Collection, http://www.lib.utexas.edu/maps/americas/txu-pclmaps-oclc-785902207-ecuador_pol-2011.jpg
Figure 3 – Quito’s Old Historic Center, showing Spanish Colonial influence in architecture and design. Photo from https://pixabay.com/p-2170520/?no_redirect
Figure 4 – The city of Quito as seen from El teleférico, showing the large skyscrapers and urban sprawl. Image from https://upload.wikimedia.org/wikipedia/commons/3/34/TelefériQo_views_of_mountains_and_Quito_-_Ecuador_-_South_America02.jpg
Figure 5 – Cuenca’s Historic Center, with Spanish colonial architectural influence. Image from https://c1.staticflickr.com/4/3745/9307175682_f5c68815bd_b.jpg

Figure 6 – Cuenca, the urban, westernizing city. Image from https://upload.wikimedia.org/wikipedia/commons/thumb/e/ea/Cuenca_%28Ecuador%29_from_Turi.jpg/1280px-Cuenca_%28Ecuador%29_from_Turi.jpg
Figure 7 – Otavalo, a smaller indigenous city. Image from https://upload.wikimedia.org/wikipedia/commons/f/f9/Otavalo_Imbabura_nina_urkuwan.jpg

Figure 8 – Otavalo market at Plaza de Ponchos. Image from https://upload.wikimedia.org/wikipedia/commons/7/7d/Otavalo_market.JPG
Data Collection

It is important to acknowledge the position of the author in relation to the communities that are being studied prior to an explanation of the methodology of data collection. As a white, American woman, I am not a member of either the indigenous communities I studied, or of Ecuadorian culture as a nonwestern society. Furthermore, the field of anthropology has long had a history of being stereotypically white and problematic in its representation of indigenous communities and developing nations. I am fully aware of these issues, including romanticizing and using patronizing language while discussing or describing indigenous groups and/or developing nations, and actively worked to ensure that my representations of those observed and interviewed in this research were neutral, considerate, and culturally respectful. I will further acknowledge my privilege and position with relation to this research in a later section, however it is important for readers to be conscious and aware of this fact while reading the methodology, data and analysis sections.

Several types of data were collected in the previously mentioned Ecuadorian cities of Quito, Cuenca, and Otavalo in order to provide a more comprehensive view of ethnomedicine usage and its commodification and appropriation in Ecuador. Prior to research, an IRB exemption form was filled out and granted approval as the intended research was found not to be strenuous, dangerous, or harmful to the participants. The original intent was to conduct interviews with pharmacy employees regarding the sale of natural medicine at various pharmacies, and to interview randomly selected individuals in public locations about their medicinal preferences for treatment of minor illnesses and maladies. However, due to difficulties obtaining individuals willing to participate, the
methods of obtaining data were altered. As the research became less invasive by eliminating the recording of participants, as well the removal of questions regarding personal preferences for medical treatment, the IRB exemption previously obtained was still in effect. This fact was verified with IRB officials at Colorado College following completion of the research.

No random individuals were interviewed, as there were no people willing to participate. Three pharmacy workers were interviewed in Cuenca after inquiring in roughly 20 pharmacies for participants. As a result of the low participation rate, a new approach to obtaining the same information was applied. Surveys containing the original research questions were given to pharmacy workers, and seven pharmacies split between two cities, Cuenca and Otavalo, were willing to complete the brief surveys. The questions asked for the age and experience working in the pharmaceutical industry of the employee, if the pharmacy sold natural medicines and for what illnesses, and whether biomedicines or natural medicines sold better in general and for specific illnesses or treatments. This led to a total of 10 survey/interview responses regarding the sale of natural medicines in biomedical pharmacies in two cities in Ecuador.

In addition to the surveys, two interviews were conducted. The first interview was conducted with Rafael Pineda Díaz, a Kichwa curandero, or healer, over a period of three visits to the Quito branch of his indigenous healing business (Figure 9). The other location of his healing business is located outside the northern city of Otavalo, a few hours’ drive from Quito. Díaz goes by Tayta Rafael when working at his clinics, and will be referred to as such for the remainder of this research. Each visit lasted approximately an hour and a half, during which he would share his family’s history of ethnomedicinal
practice, his knowledge of ethnomedicine and various treatment options, the history of ethnomedicine and the government in Ecuador, stories of healing, and his opinions on the relationship between ethnomedicine and biomedicine. During interview sessions, patients would arrive at the office and Tayta Rafael would take them behind a blanket curtain to diagnose them, prescribe plants for treatment and methods of preparation, and apply his healing techniques to his patients. The interviews were not recorded at the request of Tayta Rafael, but extensive field notes were taken during each visit with his permission.

**Figure 9** – Tayta Rafael’s business card, including a picture of him in his traditional *curandero* dress.

In Otavalo, an interview was conducted with an anonymous employee of Jambi Huasi Clinic, a clinic that seeks to offer both ethnomedicine and biomedicine side by side to better serve their community (Figures 10 and 11). This interview occurred over roughly one hour on one day. At the request of the employee, the interview was not recorded, however permission was given to take notes throughout the interview. While at this clinic, observations were also conducted of ethnomedicine in practice. It was asked that notes not be taken during these healings.
Figure 10 – Jambi Huasi Clinic, as seen from the street. Image from http://4.bp.blogspot.com/-U5jMXxKvWE/Tp4tm8nBl3I/AAAAAAAAAbo/zdfd8mp0wRw/s1600/IMG_1127.JPG
Figure 11 - Jambi Huasi Clinic as seen from the courtyard inside. Image taken from http://1.bp.blogspot.com/-WTr-VO8porQ/Tp4thU1VYQI/AAAAAAAAAbg/1eXfGaEjXvI/s1600/IMG_1126.JPG
Finally, observations were made about the medical choices made by a host family with whom I stayed for the course of four months. This family was an upper middle class family living in Quito (Figure 12). Like most families in Quito, this family maintained a small garden in which various natural medicinal plants were grown, as well as a few fruit trees and flowers. There were several pharmacies within a short walking distance of the home. The family purchased most of their food from local neighborhood tiendas, and their produce from the local mercados, demonstrating that the family chose not to shop at the more western, capitalist-style supermarkets and stores and suggesting that they may have been more likely to participate and engage in traditional Ecuadorian customs.

Figure 12 – The author and the host family. Photo taken by host father. Not pictured: one host brother.
Additional demographic and economic statistics were acquired using data from the Instituto Nacional de Estadísticas y Censos (INEC), or the National Institute of Statistics and Census, and from the Ministerio de Salud Publica, or the Ministry of Public Health website. These statistics covered a wide-range of topics relevant to this research, including the self-identification of Ecuadorians in Imbabura and Azuay provinces as well as in the specific districts of Cuenca and Otavalo, and healthcare expenditures by tenths of the population according to income and as an overall monthly expenditure. Maps and tables regarding the number and type of health care facilities in Imbabura and Azuay provinces were also gathered. These data are supplementary to the original data I collected, contextualizing the health scene in Ecuador, and providing general statistics about health spending in Ecuador with a focus on biomedicine. All the data serve as the main primary sources for this field-based research.

Results

Pharmacies and Ethnomedicinal Sales in Ecuador

Data from the ten surveys/interviews collected from pharmacy workers in Cuenca and Otavalo demonstrated that the majority of pharmacies (80%) offered ethnomedicinal options in addition to biomedicine (Figure 13). When data are broken down by city to look for demographical trends, the majority of pharmacies in both locations still sold ethnomedicinal treatments in addition to biomedical ones. 100% of the pharmacies surveyed in Otavalo sold both ethnomedicine and biomedicine treatment options, and while the majority surveyed in Cuenca also sold both (80%), the only participating pharmacies that reported selling only biomedicine options were located in Cuenca (Table 14). Five of the pharmacies reported that overall, biomedicines sold better, while two
reported that biomedicine and ethnomedicine sold equally well, and one reported that ethnomedicines sold better. Two pharmacies did not have the data to respond to this question. However, it is significant that two of the five pharmacies reporting that biomedicines sold better overall also noted that there were specific categories of illnesses/maladies in which ethnomedicinal treatments outsold their biomedicinal counterparts, which included treatments for sleep, nerves, stress, the flu, and constipation.

**Figure 13** - Raw data from surveys and interviews with pharmacies showing percentages of surveyed pharmacies offering both ethnomedicinal and biomedicinal treatments for topical maladies and illnesses in Otavalo and Cuenca, Ecuador.

**Table 14** – Ethnomedicinal sales in pharmacies by city

<table>
<thead>
<tr>
<th>City</th>
<th>Pharmacies selling both</th>
<th>Pharmacies selling only biomedicine</th>
<th>Total Pharmacies surveyed in City</th>
</tr>
</thead>
<tbody>
<tr>
<td>Otavalo</td>
<td>4</td>
<td>0</td>
<td>4</td>
</tr>
<tr>
<td>Cuenca</td>
<td>4</td>
<td>2</td>
<td>6</td>
</tr>
<tr>
<td>Totals</td>
<td>8</td>
<td>2</td>
<td>10</td>
</tr>
</tbody>
</table>

*Statistical Data from the Ecuadorian Government*

Additional empirical data were gathered from INEC, the Ecuadorian National Census. This revealed that healthcare was the sixth largest monthly household
expenditure, with households putting an average of 7.5% of their total monthly spending towards healthcare related goods and services (INEC 2015, 27). Urban households spent 7.3% of monthly income on healthcare, compared to the 8.1% spent by rural households (Figure 15). This information was further divided up into deciles (tenths) according to income per capita to highlight the difference in healthcare spending per month among populations with different incomes (Table 16). The lowest earning households, or those in the first decile, spent only 5.5% of their monthly income on healthcare, compared to the 8.4% of monthly income spent by the tenth decile comprised of the highest earning households (INEC 2015, 28). The amount spent by rural and urban households on healthcare per month also varied, as urban households spent an average of $57 USD on healthcare and rural households spent an average of $36 (INEC 2015, 28). While it cannot be assumed that this monetary difference in healthcare spending between urban and rural areas is representative of the percentage difference in healthcare spending between the first and tenth deciles, it is significant that the rural areas report higher levels of poverty and lower incomes than the more urban areas of Ecuador (INEC 2012, 22; Bravo-Ureta, Quiroga, and Brea 1996). While no definite conclusions can be drawn between the differences in healthcare spending of rural and urban areas, in USD, and the percentage of monthly expenditures put towards healthcare in both the top 10% and bottom 10% of Ecuadorians according to income, it is still interesting to note and consider.
Figure 15 – Difference in urban and rural monthly expenditures in Ecuador, 2011-2012. Bar 6 shows the difference for healthcare spending, circled in red. Image taken from El Ministerio de Salud Publica, Principales Resultados ENIGHUR 2011-2012, pg 27.

Table 16 – Percentage of Spending by Households in Ecuador, 2011-2012, divided by deciles of income (the ten percent of lowest income households are in decile 1, top ten percent of highest income households are in decile 10). The row pertaining to health expenditures is circled in red. Image taken from El Ministerio de Salud Publica, Principales Resultados ENIGHUR 2011-2012, pg 29.
Further information from INEC provided population statistics for both Cuenca and Otavalo. The data showed the difference in population from 2001 to 2010, and showed the ethnic make-up of the city, as self-identified by the population. In Cuenca, 89.7% of the population identified as mestizo in 2010, an increase from the self-reported 86.4% from the 2001 data set (Figure 17). 5.7% identified as white, a decrease from 9.6%, and 1.8% identified as indigenous, as compared to the reported 2.7% in 2001 (INEC 2010 Census Población y Viviendas). In Otavalo, 57.2% of the population identified as indigenous, an increase from 55.4%, while 40.3% identified as mestizo, a decrease from 41.8%, and 1.1% identified as white, a 0.8% decrease from 2001 (Figure 18) (INEC 2010 Census Población y Viviendas).

Figure 17 – Self-identified population composition in the canton of Cuenca, Azuay province, Ecuador, 2010. Taken from INEC at http://www.ecuadorencifras.gob.ec//resultados/
Data collected in 2015 from the Ministerio de Salud Pública del Ecuador (the Ministry of Public Health of Ecuador) provided statistics about the health care choices of Ecuadorian citizens according to their self-identification (Table 19). Health-care choices were divided into three categories. Level one was comprised of health centers and clinics, level two included basic and general hospitals, and the third level of classification contained the specialized hospitals (Ministerio de Salud Pública 2015, 32). According to the research, 2,226,008 of the people who participated in the study identified as indigenous, and 31,338,008 identified as mestizo (Ministerio de Salud Pública 2015, 20). The information was given in terms of the number of participants from each self-identified ethnic group who chose each healthcare option most frequently, however data was converted to percentages in order to be able to compare the healthcare decisions across the different self-identified groups. Of these populations, 95.5% of those who identified as indigenous sought only to receive care from health centers that were
considered to be in level one, and 86.9% of mestizos did the same. Only 4.3% of self-identified indigenous peoples sought healthcare that fell in the second level of classification, with 9.7% of mestizos seeking second level healthcare. Only 0.16% of indigenous respondents, and 3.2% of mestizos used level three healthcare options. Comparatively, the results for those identifying as white showed that 74.8% sought only first level healthcare options, 19.5% preferred level two healthcare services, and 5.6% attended healthcare options that fell into the level three categorization. This demonstrates that compared to whites, indigenous peoples and mestizos were more likely to rely on less specialized level one healthcare treatment centers, with indigenous peoples being the group least likely to seek specialized healthcare at a level three facility.


<table>
<thead>
<tr>
<th>AUTOIDENTIFICACIÓN</th>
<th>NIVELES ATENCION</th>
<th>TOTAL GENERAL</th>
<th>% TOTAL CONSULTAS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>PRIMER NIVEL</td>
<td>SEGUNDO NIVEL</td>
<td>TERCER NIVEL</td>
</tr>
<tr>
<td>Mestizo/a</td>
<td>27,277,957</td>
<td>3,054,660</td>
<td>1,005,371</td>
</tr>
<tr>
<td>Indígena</td>
<td>2,126,052</td>
<td>96,393</td>
<td>3,563</td>
</tr>
<tr>
<td>Montubio/a</td>
<td>596,263</td>
<td>56,502</td>
<td>10,856</td>
</tr>
<tr>
<td>No sabe/no responde</td>
<td>341,383</td>
<td>78,148</td>
<td>15,423</td>
</tr>
<tr>
<td>Afroecuatoriano/a</td>
<td>385,362</td>
<td>19,473</td>
<td>6,932</td>
</tr>
<tr>
<td>Afrodescendiente</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Negro/a</td>
<td>284,953</td>
<td>27,125</td>
<td>5,478</td>
</tr>
<tr>
<td>Blanco/a</td>
<td>163,829</td>
<td>42,668</td>
<td>12,303</td>
</tr>
<tr>
<td>Mulato/a</td>
<td>139,938</td>
<td>23,860</td>
<td>4,387</td>
</tr>
<tr>
<td>Otro/a</td>
<td>23,003</td>
<td>22,235</td>
<td>763</td>
</tr>
<tr>
<td>TOTAL GENERAL</td>
<td>31,338,740</td>
<td>3,421,084</td>
<td>1,063,076</td>
</tr>
</tbody>
</table>

Thematic maps produced by the INEC revealed differences between the number of healthcare establishments in Imbabura and Azuay provinces, where Otavalo and Cuenca, the cities in which data were gathered from pharmacies are located, respectively (Figure 20). These data demonstrated that Imbabura province has 119 total healthcare
Hegg

establishments including both the private and public sectors, while Azuay province has 263 healthcare establishments (INEC 2015). These maps are important because the number of available healthcare facilities in each province could be a factor in the healthcare choices of residents of these regions, or could be the result of these communities’ choices on which healthcare facilities to rely on.

Figure 20 – Total number of healthcare establishments in Imbabura and Azuay provinces, Ecuador, 2015, where data collection took place. Provinces are outlined in blue. Image from el Ministerio de Salud Publica del Ecuador http://www.salud.gob.ec/informacion-estadistica-de-produccion-de-salud/

Interviews with a Traditional Curandero

In addition to the quantitative data gathered, qualitative data was gathered through observations of my host family and interviews with both an ancestral healer and at a pluralistic intercultural health clinic. The interview with the individual healer, Tayta
Rafael Pineda Diaz, who is also known by the traditional healer name Tayta Jambik Yachak, which roughly translates to Wise Father Healer, occurred over three separate visits to his healing center, Jamby Wasy: Centro Naturista Medicina Ancestral Andina. As a result, new themes relating to ethnomedicine came up during each visit. In the first visit, Tayta Rafael detailed his family’s history as healers and practitioners of ancestral Andean ethnomedicine, and described the central healing techniques and beliefs that form the foundation of his practices.

Tayta Rafael is 72 years old, and has been formally practicing ethnomedicine for 60 years. His father and both his grandfathers were ‘curanderos’, or healers, and he believes that it was his destiny to also become a curandero. His schooling and training as a healer has been “everything” around him, including his experiences and the houses of his grandparents and father, though Tayta Rafael emphasizes that he can and must continue to learn more “until mother earth calls me”² (Tayta Rafael, Personal Interview, 10/21/16). Tayta Rafael believes that, in reality, we humans need very little – no more than love and fulfillment in health, work, relationships, and economic security. One of the central beliefs around which Tayta Rafael has built his ethnomedicine practice is his firm belief that ethnomedicine and biomedicine are healing alternatives that work together. There are things that he cannot cure, and those are things that the doctors should treat, but at other times there is a need to combine the two, and when that is the case, his job is to ensure that the doctors’ treatments go successfully by providing calming or

² The original quote is in a mix of Spanish and Kichwa, and was written down word for word and translated to English by the author because of the decisive and assured manner in which it was said. The original fragment of the quote reads “…hasta que la pacha mama me llame.”
energizing healings, etc. Another principle around which Tayta Rafael has built his practice is that he only practices for good. He acknowledges that there are many curanderos who, for lots of money, will inflict bad spirits and sicknesses on others. He distances himself from these curanderos by emphasizing that they are not real curanderos, but those who have lost their way, stating that true curanderos only work for good (Tayta Rafael, Personal Interview 11/29/16). During this interview, Tayta Rafael also spoke about the demographics of his patients— he believes that he treats equal numbers of men and women, and people of various ethnicities, including but not limited to Europeans, Americans, indígenas, mestizos, and Canadians.

During the second day of interviews with Tayta Rafael, he explained specific ethnomedicine treatments he offers and different uses of plants. The first step in treating a patient is to diagnose them. There are three main diagnostic tests that he uses - the candle test, an egg diagnosis, or a cuy diagnosis (guinea pig in Kichwa). In a candle diagnosis, a lit candle is waved around the patient and the smoke is monitored—the form and composition that the smoke takes informs Tayta Rafael on the illness/malady that the patient is suffering from. In an egg diagnostic test, a raw egg is gently rubbed all over the person, then cracked open and examined. Inconsistencies within the egg tell the curandero what is wrong with the patient. To use a cuy to diagnose patients, a live guinea pig is aggressively rubbed all over the naked body of the patient— the longer the cuy takes to die, the stronger the person is. Once the cuy has died, it is skinned, and cut open for the organs to be examined. The blood and overall health of the cuy’s organs such as the heart and lungs are seen as a reflection of the patient’s body, thus informing the healer what illness/malady the patient has.
Once the patients have been diagnosed, they receive treatment – if it is something Tayta Rafael can cure, he does so, if it is something for doctors to treat, he refers them to a hospital, but tells them to return if they wish him to provide complementary ethnomedicinal healing to aid the biomedicine. He reports that nearly all of them do return to him if he refers them to a doctor. Tayta Rafael explained the types of plants he uses for various maladies, but acknowledges that there are many different methods of treatment and diagnosing patients, and reports that he mostly treats espantos, or intense bodily frights caused by sudden impressions, such as a fight or encounters with animals, mal de la calle, which literally translated means ‘street evil,’ and pegado malaire, or ‘bad air,’ which is caused by bad spirits. He often treats patients for nervios, or nerves, and maletas, or laziness, uselessness, and wickedness, as well. To cure maletas, he creates a blend of bitter herbs, such as eucalyptus, Santa Maria feverfew, or stinging nettle, in differing amounts and quantities necessary for a specific person, in order to help rid the body of the bad energies and to provide an energetic cleaning. Another common treatment he administers to patients is a bath of flowers and sweet plants. This treatment can help harmonize the soul and spirit, or, with the correct combination of flowers and sweet plants, can bring about a person’s true destiny. Tayta Rafael notes that often people looking for love choose this treatment, but made it clear that this is not a love potion, merely a treatment that brings a person’s destiny, which could be, but is not necessarily, love.

While Tayta Rafael will offer cleanings and treatments, he does not give his patients medicines, but rather gives them instructions on which plants to buy and how to prepare and use them. He treats tumors by instructing patients to cook cheese without salt
in almond oil. He prescribes *ahi* peppers to patients to rid the body of negative energy. Tayta Rafael said it is not necessary to go to a pharmacy to buy natural medicines, though he acknowledged that some pharmacies are selling natural medicines. He prefers to send his patients to buy their medicines in the markets, where the plants are fresher and there is a wider range of medicinal plants for various classes of illnesses. He also made the point that when sick, dogs eat plants that force them to throw up, thus cleaning their stomach. This point was made to reinforce his statement that ethnomedicinal plants are just as effective as biomedicine and have been used by both humans and animals for centuries.

The third visit with Tayta Rafael turned more political, beginning with an explanation of the Hispanic government’s treatment of *curanderos* during Ecuador’s colonial period. Prior to 1979, the indigenous *curanderos* of Ecuador were primarily left alone, although many were pushed off their native lands and into the surrounding areas (Clark and Becker 2007). Then, between 1979 and 1981, the colonial powers forbid *curanderos* from practicing their medicine. The authorities and the ministry of public health went as far as to take their healing instruments and tools and prosecute those *curanderos* who kept practicing or hid their tools. The indigenous *curanderos* organized an association, which became the first association of healers. They considered this organization to be a parish within their communities. Presently, they have regained the right to practice their ethnomedicine openly, and the association sponsors festivals of health where at least 35 to 40 *curanderos* go to treat patients and educate the public about their practices.
As each conversation with Tayta Rafael inevitably resulted in storytelling about different cases he had cured and people he had treated, he drifted away from the political conversation into discussions on emotional healing. Tayta Rafael cures emotional distress—caused by negative energy, often from having *espantos* - using a bitter plant cleanse and a bath of flowers. This combination allows the soul and aura to harmonize once again. Furthermore, Tayta Rafael mentioned that it is possible to combine different treatments and plants for a more rapid healing process.

*Jambi Huasi Causi, an Intercultural Health Clinic*

In addition to the interviews with Tayta Rafael, an interview was conducted with an employee at Jambi Huasi Causi, a medical clinic in Otavalo that has created a space for both ethnomedicine and biomedicine. The clinic began as a response to the lack of healthcare attention given to indigenous and mestizo populations in rural areas of Ecuador. One of the clinic’s organizing beliefs is that “one can only understand health and healthcare in its social and cultural context” (Jambi Huasi Causi, Personal Communication, 11/18/2016). In accordance with this principle, and in order to serve these populations, the clinic saw the need to provide ethnomedicine options as well as biomedicine, and ensures that all employees can attend to the patients in either Spanish or Kichwa. The biomedicine doctors are trained in universities, while the majority of ethnomedical healers learn from their families, although a few attend a university in Rio Bamba in the southern highlands region of Ecuador that offers traditional and Andean medicine.

The clinic tends to at least 35 people every day, and reports that 78% of their patients identify as mestizo, while 6% identify as indigenous. Though an intercultural
clinic, Jambi Huasi Causi is not entirely integrated, as the curanderos are not doctors nor do the doctors have any ethnomedicinal training. Both the doctors and curanderos have their own offices and patients are welcome to seek treatment at either option or at both. In addition to running the clinic, the organization also sends employees into rural communities to teach about health, provide medical attention to indigenous women who are often unable to leave the home due to child-raising and household management duties, and learn how the clinic can better serve the communities. The greatest difficulty the clinic faces is in trying to provide sexual education for the communities they serve. This subject is difficult because the clinic needs to respect both the religious beliefs and the indigenous traditions and beliefs of these rural communities.

While visiting this clinic, there was the opportunity to observe several ethnomedicinal diagnostics and treatments. The first was an egg diagnostic test. In this case, the patient was diagnosed with espantos. The patient was treated using plants, oil, and water that was potentially infused with other plants or essential oils. The oil was drizzled into the hair and rubbed on the forehead, and the plants were rubbed up around the head. The patient reported feeling rejuvenated and significantly more relaxed and energetic following the treatment.

The second diagnostic observed was a cuy diagnosis. The live cuy was rubbed vigorously up and down the upper body of the patient, who was shirtless. The cuy was held by holding the hind feet together and front arms together, and whimpered and squeaked throughout the process. Occasionally, the curadero had to pause and hold the cuy off to the side, as it is common for frightened cuy to defecate and urinate as a fear response. This process of rubbing was repeated until the cuy was dead. The longer the
cuy lives, the healthier and stronger of heart the patient is said to be. Next, the cuy was skinned and cut open to examine the internal organs. The organs of the cuy reflect the organs of the patient, and therefore any irregularities found in the cuy are irregularities within the patient causing them to be sick. This patient was found to be incredibly healthy, with no illnesses or maladies.

The final treatment observed was an energizing healing. This took place in a different office than the prior two diagnoses. The first two took place in an open room with large windows and wall tiles popular throughout Ecuador, and contained a classic western medical examination table, a chair, a bench, and a counter. The next room was dark and cool, with no windows, made of rock and cinder blocks, and lit by candles. There were jars and bottles of oils and dried plants, as well as baskets of fresh ones. The patient was sitting in a chair, and the healer rubbed a combination of oils and plants over the face, hair, and neck. The specific combination was intended to cleanse the spirit and reenergize the patient.

Observations of an Upper-Middle Class Ecuadorian Family

The final component of the qualitative data was comprised of observations made of a host family with whom I stayed for four months throughout the research. The mother was the primary focus of the observations, as she was open about her own healthcare decisions and would discuss them without prompting. The family had a garden in which the mother grew several medicinal plants that were used to make various teas. The most common tea served was a tea intended to aid in digestion and to calm the drinker. This tea was served after dinner almost every night. The other main plant the mother used to make tea was for treating colds, and was mainly given to the host sister who maintained a
cold throughout two of the four months. In addition to this tea, the host mother also purchased ginger and various plants from the market to make other teas intended to ease coughs and soothe throats. A special tea was made on one other occasion, using a plant from the far corner of the garden, which was never used previously. This tea was made only when I contracted cholera following a visit to a rural coastal town, and was intended to soothe the stomach; however, I was unable to drink more than a sip or two of the tea due to an inability to keep down any sort of liquid, and thus the effectiveness of this ethnomedicinal treatment can be neither confirmed nor denied by me.

The healthcare choices the host mother made for herself were also observed. The family had the means to visit both general hospitals and specialized hospitals, and indeed this was where the host mother went initially to treat several medical issues and pains she was experiencing. She was prescribed pills; however, she complained that they made her dizzy and ill and consequently stopped taking the pills. Instead, she began a strict diet that increased the amount of vegetables and fruits she was consuming and decreased the amounts of carbohydrates drastically. She also began to buy plants and make a special juice-like mixture that she drank every morning. She immediately reported feeling better, with no more experiences of dizziness or feeling ill, and shunned the pills the doctor had given her publicly to her friends who came over for coffee, rather than keeping her criticisms and complaints confined to family members as she had prior to this change in health.

Throughout the research process, large quantities and varieties of data were collected. The statistics on healthcare choices, monthly expenditures, percentages of indigenous and mestizo populations, and number of pharmacies that reported selling
ethnomedicines all work together in an examination of the commodification and appropriation of ethnomedicine through the lens of the indigenous revitalization movement, which will be analyzed in the following section.

**Cultural Analysis**

**Revitalization Theory**

The theory of revitalization movements is relevant to this study because a deeper understanding and analysis of the movement in Ecuador is necessary for comprehension of the relationship between the commodification and appropriation of ethnomedicine and the movement itself. Determining the nature of the relationship is essential for examining the effects on Ecuadorian citizens, community cultures, and society as a whole.

A prominent scholar on revitalization theory is Anthony F.C. Wallace. Wallace (2003) defines a revitalization movement as “a deliberate, organized, conscious effort by members of a society to construct a more satisfying culture” (Wallace 2003, 10). He argues that revitalization movements, as a type of culture change, do not follow the typical chain-like and self-contained procession of change, but rather are shifted into process abruptly and can create change within one generation, as suggested by Mead (1957) (Wallace 2003). Wallace classifies several types of revitalization movements, however, the most applicable to this study is the “revivalistic” movement, which “emphasizes the institution of customs, values, and even aspects of nature which are thought to have been in the mazeway of previous generations but are not now present” (Wallace 2003, 13). Wallace uses the term ‘mazeway’ to refer to an individual’s perception of the sociocultural landscape in which they are a participant, and that which determines their behavior.
Wallace’s model for the structure of revitalization posits that there are five overlapping stages: steady state, period of individual stress, period of cultural distortion, period of revitalization, and finally, new steady state (Wallace 2003, 14). In the first stage, steady state, the vast majority of the population satisfies their needs with culturally recognized techniques, though tolerable stress may remain among the population (Wallace 2003). In the second period, individuals of a population experience increasingly severe stress as a result of the decreasing efficiency of cultural techniques (Wallace 2003). During the period of cultural distortion, people respond differently to the stressors rather than using the culturally recognized techniques (Wallace 2003). In the revitalization period, the mazeways are reformulated, adapted, changed, and routinized (Wallace 2003). After the routinization of the new mazeways, a new steady state, the fifth period, has been established (Wallace 2003).

For revivalistic movements, the period of increased stress is “often, but not necessarily, one of acculturation, and the acculturating agents may or may not be representatives of Western European cultures” (Wallace 2003, 15). This causes increased stress because of the concern about the effectiveness of the new substitute way, its interference into other practices, and poses the threat of destroying the mazeway system (Wallace 2003). This leads to a resurgence of the old traditions and practices thought to have been previously in the mazeway but that are now less prevalent or popular in the revitalization period of Wallace’s structure of the movements (Wallace 2003). These old traditions and values being reinstilled in the mazeways and social norms becomes routinized and established as normal, and with the cultural transformation accomplished
and proved viable, the society then moves into a period with a new steady state (Wallace 2003, 23).

Although almost all revitalization movements contain traditional and imported cultural material in their proposed new cultural systems, “each movement tends to profess either no identification at all, a traditional orientation, or foreign orientation” (Wallace 2003, 24). This identification choice shows that there are positive and negative connotations surrounding both the foreign and traditional, and indicates that the indigenous revitalization movement in Ecuador could have both positive and negative effects.

*Relationship between Commodification of Ethnomedicine and Indigenous Revitalization*

The relationship between the commodification and appropriation of ethnomedicine and the indigenous revitalization movement may have been unclear prior to a better understanding of revitalization theory, however this theory will help make it obvious how Ecuador’s indigenous revitalization movement has played a large part in the commodification and appropriation. As a revivalistic movement, while the indigenous revitalization movement has advocated for a return to Andean indigenous traditions, it has also worked to obtain recognition of these traditions and to create a more intercultural, pluralistic society in Ecuador. It has done so through advocating for more indigenous participation in politics and government (Colloredo-Mansfeld 2009, Clark and Becker 2007, Lalander 2010). As a result of the movement and the success it experienced in creating governmental change, indigenous pride has increased and more Ecuadorians feel comfortable identifying with their indigenous roots, as seen in the shifts in self-identification from 2001 to 2010 in both Cuenca and Otavalo (INEC).
These shifting values and self-identifications demonstrate that the indigenous revitalization movement has managed to shift what the theorist Durkheim termed the ‘collective consciousness’ of Ecuadorian society (Moberg 2013). Collective consciousness, or “society’s shared system of beliefs and values” imposes on individual behavior (Moberg 2013, 93). Thus, prior to the movement, indigenous traditions, such as ethnomedicine, were confined to indigenous communities in mostly rural populations as Spanish colonial influence and increasing exposure to western culture due to globalization gradually removed these traditions from the shared values and beliefs of Ecuadorian society. However, the indigenous revitalization movement increased indigenous pride and revitalized these traditions first in rural areas with higher populations of indigenous communities and, as the movement advocated for participation in politics and government, awareness of this movement spread throughout Ecuador (Wallace 2003). While more and more indigenous and mestizo populations also migrated to the city for jobs and other economic opportunities, the political activism and economic migrants helped create a larger change in public perceptions on indigenous culture and traditions. The increasing popularity of ethnomedicinal businesses and food-cart style medicinal stands run by curanderos who cater to indigenous and mestizo populations as well as to tourists from Europe and the Americas also exemplifies how the indigenous revitalization movement has increased visibility and acceptance of ethnomedicinal practices throughout Ecuador.

As the governments of countries such as Nicaragua and Bolivia have formally recognized and begun the shift to intercultural, pluralistic healthcare systems, the UN has also passed the UNDRIP, which contains in article 24 an acknowledgement of the rights
of indigenous communities to their traditional medicinal practices (Carrie et. al 2015). This article reads, “Indigenous peoples have the right to their traditional medicines and health practices, including the right to the protection of vital medicinal plants, animals, and minerals. They also have the right to access, without any discrimination, to all medical institutions, health services and medical care” (UNDRIP article 24, cited from Posey 2004). The passage of the UNDRIP and actions of the indigenous revitalization movement have helped to increase acceptance of ethnomedicine throughout the general Ecuadorian public, demonstrated by the fact that pharmacies have begun to sell ethnomedicinal treatments as alternatives to over-the-counter treatments. Eight of the ten pharmacies surveyed responded to a question inquiring whether biomedicine or ethnomedicine sold better overall. One pharmacy reported that the ethnomedicinal options are more popular than the biomedical ones, which could be a factor of the different self-identification statistics of the cities in which the data was taken. The pharmacy that reported higher sales of ethnomedicinal treatments compared to biomedicine options was located in Otavalo, which also reports significantly higher indigenous and mestizo self-identification rates compared to Cuenca (INEC 2010). Two pharmacies reported that both options sold equally well, and of these, only one was located in Otavalo; the other was located in Cuenca. This finding was surprising, since one would expect that higher populations of indigenous and mestizos would tend to increase the sales and popularity of ethnomedicine more in Otavalo and less so in Cuenca. However, the fact that a pharmacy from Cuenca also reports equal sales of ethnomedicine and biomedicine suggests that that pharmacy could be located in a neighborhood with a higher indigenous or mestizo population, and/or demonstrate that
Ethnomedicinal treatments are gaining in popularity across ethnic groups in Ecuador as a result of the indigenous revitalization movement.

Interestingly, while the five other pharmacies responding to this question all reported that biomedicine outsold ethnomedicine overall, two of them also reported that there were specific illness areas in which ethnomedicine outsold their biomedical counterpart; the pharmacy that reported that both sold equally well also reported that illness areas existed in which ethnomedicinal options sold better than the biomedicine options. These illness areas included treatments for stress, sleep, nerves, constipation, and the flu. Of these three pharmacies reporting that ethnomedicine sold better than biomedicine for these areas, two were located in Otavalo, and one was located in Cuenca. This suggests that ethnomedicinal treatments for minor illnesses and maladies are gaining recognition in these areas of illness throughout Ecuador, regardless of ethnicity or class. While it would be a worthwhile study to examine why Ecuadorians tend to turn to ethnomedicinal treatments for these areas of illness more than others, this unfortunately falls outside the scope of this study due to time constraints and other limitations.

Another important aspect of the study to consider is that while all data come from pharmaceutical sales of ethnomedicine, Tayta Rafael, the curandero with two successful ethnomedicinal clinics in Otavalo and Quito, said that he prefers to send his patients to markets to buy plants for treatment rather than to pharmacies to buy the ethnomedicinal treatments sold there. He does so because it allows him to adjust his treatment prescriptions to tailor to the needs of each individual patient. If all curanderos similarly send their patients to markets, it complicates the understanding of how substantially the indigenous movement has contributed to the rise of ethnomedicine. Tinitana et. al (2016)
researched sale of medicinal plants at markets in the southern highland region of Ecuador, specifically in the province of Loja, and concluded that low prices and civilian trust in *curanderos* allowed these markets to continue and prosper. This trust component of the rationale behind the success of natural plant markets is significant because it shows that the indigenous revitalization movement is not only advocating for the return to traditional medicine systems but is also allowing for *curanderos* to be able to gain the trust of mestizos or indigenous families who had migrated to urban areas and abandoned many traditions, and reinforces this trust with rural Ecuadorians who hadn’t abandoned these traditions. The conclusion that low price is also an important factor is also necessary to consider because it raises the question of the role of the price of medicine in these choices that are being made by patients.

*Cultural Implications and Effects*

While western countries and pharmaceutical companies with vested interests in Latin and South American markets promote biomedicine options, it is likely that these options are more expensive for Ecuadorians due to the manufacturing costs (Posey 2004). Thus, it is interesting to consider that a manufactured ethnomedicinal treatment such as a tea or a tincture sold at a pharmacy would cost more than a natural plant sold at a market. Therefore, the fact that ethnomedicine is being commodified and sold in pharmacies suggests that this success of the indigenous revitalization movement is also an appeal to those who, upon moving to urban areas for economic success, abandoned their traditional medicinal practices in order to better fit into the more westernized culture present in urban cities in Ecuador, demonstrating the maintenance of cultural traditions while adapting to pressures of westernization. However, these manufactured ethnomedicinal
treatments do not only contribute to increased usage for members of indigenous communities who migrated to urban areas, but are also being appropriated by and marketed to members of the upper class and nonmembers of indigenous communities. The idea that the commodification of ethnomedicine not only makes this tradition more easily accessible to urban indigenous and mestizos who want to use it, but also to nonmembers of these communities who appropriate it for their own gain will be discussed later.

The rise of intercultural healthcare clinics such as Jambi Huasi not only in Ecuador but also in other similar South American countries has exemplified how hospitals and healthcare centers are recognizing the need to cater and serve all populations (Bruun and Elverdam 2006, Torri 2012). These intercultural healthcare facilities take various forms as integrating biomedicine and ethnomedicine in a way such that no one option is subservient to the other is a difficult process that involves shifting the mazeways in which people think and understand the world surrounding them (Gold and Clapp 2011). When analyzing intercultural healthcare clinics, it is important to return to the previous conversation on cost. Perhaps the reason that intercultural clinics such as Jambi Huasi Causi are becoming more popular is because they allow more people to receive healthcare that they can afford, since a curandero prescribing natural plants should be a more affordable option than a doctor prescribing a manufactured western pill. The prominent anthropologist Franz Boas wrote that, “Cultural life is always economically conditioned and economics are always culturally conditioned” (Moberg 2013, 145). Essentially, this posits that the cultural rise of ethnomedicine could be partially attributed to the economic reasons of lower prices for ethnomedicines, and that
this rise caused the commodification and appropriation because economic policies and actions are influenced by cultural conditions.

Returning to the idea that indigenous medicine is being commodified and sold at pharmacies, it is necessary to realize that this commodification is not only a “conscious effort to maintain ‘traditional culture’” but also essentially a manner of conforming to the pressures of globalization and westernization (Hall and Fenelon 2009, 7). By mass producing indigenous knowledge and healing practices, and then selling these mass produced products at pharmacies which are stores representative of western culture, the importation of western culture into a renewed indigenous tradition through the commodification of ethnomedicine and its subsequent sale at pharmacies and stores signifies how the revivalistic-style revitalization movement of Ecuador is also leading to the appropriation of ethnomedicine and sale to cultural tourists (Wallace 2003).

The idea that the indigenous revitalization movement can simultaneously have positive and negative effects relates back to the idea that revitalization movements must proclaim themselves to be either oriented towards the traditional or the foreign but cannot claim to be both (Wallace 2003). This reveals that both the foreign and the traditional have positive and negative complications, which inherently complicates the relationship between ethnomedicine and the movement. On the one hand, the indigenous revitalization movement is allowing for widespread acceptance of ethnomedicine, and is permitting urban indigenous and mestizo migrants to reclaim their cultural heritage and practices without fear of breaking the collective consciousness, and to have easier access through the commodification; however, at the same time, it is leading to the perpetration of cultural appropriation of indigenous culture. The increased public acceptance and more
widespread use of ethnomedicine has led to western interests in pharmacies and medical fields to see the value of ethnomedicine, and to begin to enter this field by mass producing natural medicines made using ethnomedicinal traditions learned from *curanderos* and other indigenous shamans and healers (Plotkin 1994).

The sale of these items in western pharmacies and the governmental reforms pushed through by politicians associated with the indigenous revitalization movement have led to the appropriation of ethnomedicine by members of the Ecuadorian upper class. These Ecuadorians are typically whiter, claiming more European heritage than the rest of Ecuadorian society, and have the luxury of being afforded certain privileges due to the color of their skin (personal observation 2016). The ethnomedicinal practices are also being appropriated by cultural tourists who travel to Ecuador seeking natural treatments that they have heard about and want the excitement of a ‘non-traditional,’ or ‘other’ treatment, or who have exhausted their biomedical possibilities and place all their last hopes in ethnomedical options (Costa, Quintela and Mendes 2015; Plotkin 1994).

Finally, another aspect of the relationship between the indigenous revitalization movement and the commodification and appropriation of ethnomedicine that is important to the study is the idea that indigenous groups present today are not “living fossils,” but rather evolved cultures that have “changed and adapted to a context in which it has been surrounded” (Hall and Fenelon 2009, 15). In the framework of this paper, this means that although the commodification of ethnomedicine is a stark drift away from traditional methods of acquiring ethnomedicine, it is simply one way that indigenous members have adapted their culture to work within the “hostile states” that surround them, or, in other words, learned to adapt to the pressures presented by the influences of western culture,
capitalism, and globalization while maintaining important aspects of their traditions (Hall and Fenelon 2009, 15).

Significance of the Relationship

The relationship between the indigenous revitalization movement and the commodification and appropriation of ethnomedicine is important because the commodification not only reflects the success of the indigenous revitalization movement, signifying a broader societal acceptance of a variety of traditions and customs, but also because it informs the ways in which Ecuadorian citizens can navigate and understand their position in a developing nation experiencing the effects of globalization and westernization. The indigenous revitalization movement’s contribution to the valorization of indigenous culture has allowed for the maintenance of more cultural traditions, and simultaneously has provided a mazeway for understanding and taking partial ownership of the globalization. The commodification of ethnomedicine has popularized ethnomedicine and provided urban indigenous and mestizo populations opportunities to reconnect with their heritage and traditions, while also increasing acceptance by nonmembers (Rosales-Rivadeneira, Álvarez-Moreno, and Tito-Pineda 2017). This is simultaneously a way of challenging the hegemonic ideologies of western society. 

Hegemony, a term coined by Antonio Gramsci, is a concept that refers to ideological control that represents an existing social order as natural and desirable in order to prevent populations from challenging this order (Moberg 2013). As colonization and globalization have led to the increased prevalence of western ideologies, they have been presented as the natural and desirable manners of societal order. This includes biomedicinal treatments as the natural and desirable way to treat common illnesses. By
promoting and valorizing ethnomedicine, the indigenous revitalization movement has challenged the hegemonic ideologies in Ecuador.

However, this challenge produced by the indigenous revitalization movement has also contributed to the appropriation of these traditions by attracting cultural tourists and use of these medicines by nonmembers. Furthermore, it is likely that the pharmacies selling these ethnomedicines are not owned (or at least the majority are not owned) by indigenous families, and therefore the profits from these ethnomedicines are not going back to the communities from which these traditions have been taken and appropriated. This is a significant implication that needs to be addressed and considered. While the revitalization movement has had many positive impacts on Ecuadorian society and for indigenous communities, this is one aspect that is negative.

The indigenous movement itself has had significant impact on Ecuadorian society, from helping indigenous communities become more involved in local, regional, and national politics to making important progress in land reform and recognition of rights, but it has also contributed to cultural appropriation of indigenous traditions. Cultural appropriation is a very nuanced topic today, and many participants in conversations are divided on individual cases of appropriation due to the uncertainty of not knowing when it is “acceptable for actors who do not share the social experience common to the members of a marginalized collectivity to witness, experience, adopt, or rework the scientific, artistic, productive, and religious practices characteristic of the cultural life of that collectivity” (Berson 2010, 205). Regardless of where one stands on this line in each case, it is necessary to understand that it is unacceptable for non-group members to reap the benefits of the intellectual and cultural properties of another group.
from whom they have appropriated ideas, goods, or traditions without returning a
significant portion of the rewards to the group from which the goods, ideas, or traditions
came. This means to say that if the popularity and commodification of ethnomedicine in
Ecuador is to continue, it will be crucial for some fundamental changes to occur in order
to resolve this issue (Posey 2004).

Conclusion

The indigenous revitalization movement occurring in Ecuador has undoubtedly
contributed to the commodification and appropriation of ethnomedicine. The
revitalization movement has led to increased acceptance of indigenous traditions and
increased indigenous pride, which has helped to shift the collective consciousness of
Ecuadorian society (Moberg 2013). This shift has made ethnomedicine more acceptable.
The maintenance of traditional indigenous practices is also a form of resistance,
challenging the hegemonic ideologies of western and colonizing societies. At the same
time, the return to indigenous traditions has led to the commodification of ethnomedicine,
allowing urban indigenous and mestizo populations to reclaim their medicinal practices,
and have easier access to ethnomedicine. These shifts signify the manners in which
indigenous communities are maintaining their traditions while simultaneously adapting to
the effects of colonialism and globalization (Hall and Fenelon 2009). However, this
commodification has also led to the use of ethnomedicine by many nonmembers of these
groups, and the increasing popularity of alternative medicinal practices in western society
has contributed to the appropriation of ethnomedicine through cultural medical tourism
and by white Ecuadorians.
Limitations and Implications for Further Research

Similar to all studies, this research had limitations that impact the breadth of the findings. Firstly, the appearance, background, and biases of the author must be taken into account. As mentioned, as a white American female, I am an outsider in not only the indigenous communities but also in Ecuadorian society. This undoubtedly influenced the findings of this study by playing into the interviewer effect, as respondents likely modified their answers or behaviors as a result of “the identity (nationality, race, gender, age, etc.) of the researcher” and skewed how people answered the questions posed in interviews and/or surveys (Moberg 2013, 28). Furthermore, as a nonmember of the indigenous communities and Ecuadorian society at large, it is important to note that despite attempts to maintain neutral and unbiased, my own previous experiences with medicine and healthcare were likely brought into interviews, observations, and while analyzing survey results. It is also important to acknowledge the privilege I have in studying anthropology, and to acknowledge anthropology’s problematic history in representing those considered to be cultural “others.” While engaging in the research and writing processes, I tried to ensure that all representations of indigenous communities and Ecuadorian society were not only neutral, but also culturally respectful and considerate, and to avoid romanticizing the cultures or using patronizing language. Finally, it is also necessary to acknowledge that while I have a highly proficient level of Spanish, it is my second language and I speak only a few words of Kichwan. This is definitely a limiting factor to the interviews that were conducted as some plant names and treatment explanations may have been mis-recorded or misunderstood due to my language limitations. Additionally, I was not always allowed to take notes or photos in some of the
treatment observations, and recorded observations from memory as soon as possible after the events, thus leading to an additional increase in the potential for inaccuracies in the recording.

Due to time constraints and difficulty obtaining willing participants in pharmacies, only ten pharmacies were surveyed in two cities in Ecuador, and only one curandero and intercultural health clinic were interviewed. This is a relatively small sample size to provide a reliable, rounded view of the commodification of ethnomedicine in Ecuador, and future research could examine more pharmacies, curanderos, and intercultural healthcare clinics to see if the findings are consistent across more cities and workers. Additional statistical information about the ethnic and economic backgrounds of people treated by curanderos could also prove helpful to fully understand the implications of the relationship between the indigenous revitalization movement and the commodification of ethnomedicine.

Another limiting factor is that the research was confined to the highlands Sierra region of Ecuador, which ignores the indigenous activism in the Amazonian region. The Amazonian region of Ecuador is known for having a very politically and socially active indigenous movement due to attempts to drill for oil on indigenous lands and these communities’ desire to protect the Amazon rainforest from deforestation by farmers, cattle-ranchers, and other groups (Colloredo-Mansfeld 2009; Clark and Becker 2007). Future studies on the commodification of ethnomedicine and the indigenous revitalization movement should gather information from more pharmacies in more geographical zones of Ecuador to determine if this relationship is the same throughout different indigenous regions.
Furthermore, ethnomedicinal sales in pharmacies do not necessarily translate to total usage of ethnomedicine. Tayta Rafael reported sending his patients to buy the necessary items for their treatments in local markets, and therefore the reports from the pharmacies on sales of ethnomedicine versus biomedicine options are not a complete overview on the popularity of ethnomedicine. Visiting markets and asking the sellers of natural plants what percentage of plants they sell can be used as ethnomedicinal treatments and how well these plants sell could prove to be useful for informing future research.

When visiting pharmacies, the prices of ethnomedicine and biomedicine treatments for the same illnesses were not examined. Nor were prices of various treatments from curanderos or at intercultural healthcare facilities taken into account. Within the ethnomedicinal treatment options these prices are also likely to vary between the different avenues (pharmacy versus curandero and market versus intercultural healthcare clinic) and along different urban and rural regions. Price is obviously a contributing factor to the healthcare choices that individuals and families make, and was not taken into account in this research. This is a large oversight in this study, and is definitely an aspect of this relationship that future research should look into.

Additionally, it is important to acknowledge that this study focused only on ethnomedicinal treatments that are alternatives to over-the-counter pharmaceutical options. This excludes the realm of magic and spirits that is present in the majority of ethnomedicinal beliefs across various indigenous cultures but absent in biomedicine. Due to the absence of the aspect of magic in biomedicine, there are few comparative biomedicinal treatments sold at pharmacies, and therefore this area of ethnomedicine was
excluded from the study. Future research could examine the relationship between magic and ethnomedicine and look for the commodification of magical aspects of ethnomedicine, as a continued popularity of ethnomedicine could lead to an increase of the prevalence of these aspects of ethnomedicine.

Finally, the study has a lack of information on public perceptions of ethnomedicine and biomedicine that would have proved quite helpful to understanding the ways in which Ecuadorians are conceptualizing the commodification of ethnomedicine and the indigenous revitalization movement. Future research should examine which medicinal options people prefer in general and for various treatments and why, as well as their general impressions on ethnomedicine. This would help deepen not only the understanding of the relationship between ethnomedicine and the revitalization movement, but would also provide information about the shifting collective consciousness of Ecuadorian society with regards to ethnomedicine and indigenous traditions.

Despite the many limitations of this study, the holistic approach to understanding the ways in which the indigenous revitalization movement has contributed to the commodification and subsequent appropriation of indigenous medicine has provided an interesting perspective. This furthers the discipline of anthropology by contextualizing the rise of ethnomedicine in the revitalization movement, and by providing an outline for indigenous communities to better understand how to navigate increasing globalization while maintaining and reviving indigenous traditions. Furthermore, it is important for the colonizing/western countries to recognize the role they play in shaping these movements and how to provide support for the maintenance of cultural traditions without
appropriating or taking the benefits away from indigenous communities. Further research could better enhance these findings by filling the gaps in this study left by the limitations, and continue to inform indigenous communities and colonizing cultures on how to interact and navigate the globalization while maintaining traditions.
References


